National Coordinating Committee on School Health

Annual Meeting Minutes
May 22-23, 2002

The annual meeting of the National Coordinating Committee on School Health (NCCSH) was held on May 22–23, 2002 at Loews L'Enfant Plaza Hotel in Washington, DC. Representatives from Federal agencies, national non-governmental organizations (NGOs), and other organizations with interests in school health and education participated in the meeting.

Participating Organizations

Federal Agencies:

U.S. Department of Health and Human Services (HHS)
- Centers for Disease Control and Prevention (CDC)
- Food and Drug Administration (FDA)
- Health Resources and Services Administration (HRSA)
- Indian Health Service (IHS)
- National Institutes of Health (NIH)
- Office of Disease Prevention and Health Promotion (ODPHP)

U.S. Department of Education (DoEd)
- Office of Special Education Programs (OSEP)
- National Institute on Education Governance, Finances, Policymaking, and Management
- Safe and Drug-free Schools Program (SDFSC)

U.S. Department of Agriculture (USDA)

U.S. Department of Justice (DOJ)
- Office of Juvenile Justice and Delinquency Prevention (OJJDP)

U.S. Department of Transportation (DOT)
- National Highway Traffic Safety Administration (NHTSA)

U.S. Department of the Interior (DOI)
- Bureau of Indian Affairs (BIA)

National Non-governmental Organizations:

American Academy of Pediatrics (AAP)
American Association for Health Education (AAHE)
American Association of School Administrators (AASA)
American Cancer Society (ACS)
American Dental Association
American Diabetes Association
American Medical Association (AMA)

American Occupational Therapy Association (AOTA)
American Psychological Association (APA)
American School Food Service Association (ASFSA)
American School Health Association (ASHA)
Association of Maternal and Child Health Programs (AMCHP)
Association of State and Territorial Chronic Disease Program Directors (ASTCDPD)
Association of State and Territorial Directors of Health Promotion and Public Health Education (ASTDHPPHE)
Association of State and Territorial Health Officials (ASTHO)
Association for Supervision and Curriculum Development (ASCD)
Council of Chief State School Officers (CCSSO)
National 4-H Council (4-H)
National Association of School Nurses (NASN)
National Association of School Psychologists (NASP)
National Association of Social Workers (NASW)
National Association of State Boards of Education (NASBE)
National Association of State Directors of Special Education (NASDSE)
National Center for Health Education (NCHE)
National Conference of State Legislatures (NCSL)
National Mental Health Association (NMHA)
National Safe Kids Campaign (NSKC)
National School Boards Association (NSBA)
Partnership for Prevention (PFP)
Public Education Network (PEN)
School Health USA
Society for Public Health Education (SOPHE)
Society of State Directors of Health, Physical Education and Recreation (SSDHPER)

Other Groups:

The Center for Health and Health Care in Schools
Children's National Medical Center
Funder's Forum on Environment and Education
Harvard School of Public Health Partnerships for Children's Health
Maryland State Department of Education
Michigan State Department of Community Health
Mid-Atlantic Dairy Association
University of Maryland, Center for School Mental Health Assistance

Meeting Chair

Dr. Becky Smith, Vice President of the American Alliance for Health, Physical Education, Recreation and Dance (AAHPERD) and Executive Director of the American Association for Health Education (AAHE).

Meeting Organizers

The meeting was developed by the Steering Subcommittee of the NCCSH. Rena Large of the Association of Maternal and Child Health Programs (AMCHP), Clare Miller (USDA), William Potts-Datema (NCCSH Consultant), and Dr. Trina M. Anglin, (MCHB-HRSA) prepared the agenda using the guidance of the Steering Subcommittee.

William Potts-Datema, Dr. Anglin, and Dr. Smith organized the meeting.

Day One
May 22, 2002

Section Title: Welcome and Introductions

Dr. Smith welcomed the assemblage and invited participants to introduce themselves.

Dr. Smith set the tone of the meeting by reviewing NCCSH's organizational objectives. NCCSH's objectives are:

1. To provide national leadership for the promotion of quality coordinated school health programs (CSHPs);
2. To convey a clear vision of the role of school health programs improving health, safety, mental health, nutrition, and educational achievement of children; and
3. To facilitate communication and collaboration among national organizations.

Participants were invited to share their thoughts about NCCSH's objectives. This discussion segued into comments about NCCSH's view of shared responsibility between health and education.

Section Title: Opportunities of the Elementary and Secondary Act of 2001, The No Child Left Behind Act

Mr. Potts-Datema led a discussion on the health-related provisions of the *No Child Left Behind Act of 2001* (NCLB), the reauthorization of the Elementary and Secondary Education Act (ESEA) that was first enacted in 1965. In summary, the four basic education reform principles in *No Child Left Behind* are:

- stronger accountability for results,
- increased flexibility and local control,
- expanded options for parents, and
- an emphasis on teaching methods that have been proven to work.

These principles constitute the foundation for significant changes that will be seen in state educational systems, local school districts, and individual schools in the next few years.

Nora Howley (CCSSO) offered that her organization and many others are pleased and encouraged that NCLB was passed. She said the reauthorization of ESEA brings a "great sense of relief and optimism" to many. She reminded the participants that not everyone got exactly what they wanted from the act. The education community can look at NCLB as an opportunity to put high quality programs in place. NCLB also represents a national commitment to establishing high standards in education. We can no longer think that some children won't learn. Every child will now be held to higher standards and all will be expected to achieve higher outcomes.

Brenda Greene (NSBA) said that state school boards are still operating without regulations with regard to NCLB, and that dialogue between state school boards and local school boards is imperative. The needs from community to community vary, and NCLB will not, in its current form, fit all of the needs of all of the communities.

Susan Wooley (ASHA) stated that there are provisions in NCLB for a variety of school health issues. The appropriations for services for children address some critical needs. For example, a larger amount of money will be allocated for Safe and Drug Free Schools. However, Dr. Wooley wanted to bring attention to other needs in school health. She suggested that an example for other increased appropriations is school counselors or other mental health delivery systems.

Libby Nealis (NASP) suggested that it wasn't quite clear what the Federal role is and that it would be helpful to hear the energy behind promoting NCLB on an ongoing basis. She said the provisions placed within the *Safe and Drug Free School Act* are logical. She added that there are other areas under Title IV that call for coordination among school health-related agencies, particularly in looking at the flexibility of provisions and the transferability of funds.

Stephanie Bryn, of Injury and Violence Prevention at the MCHB (HRSA), brought the focus of the discussion back to more specific NCCSH issues. Ms. Bryn pointed out that NCCSH's mission statement and objectives need to include the word "safety" more often to indicate that NCCSH is aware of how critical safety is to children's health.

Section Title: Sharing Responsibility for Health and Education Outcomes for Children and Youth: Commentary and Discussion from National Non-governmental Organizations Representatives

Presenter: John Clymer
President
Partnership for Prevention (PFP)

Cultivating the relationship between business and school health professionals as a means to promote the health of the Nation's children is important, according to John Clymer, President of Partnership for Prevention. Businesses should be concerned with the health of the Nation's children because their health status influences the future workforce. Mr. Clymer said Partnership for Prevention has learned that the way to get businesses involved in health issues is to put health in their terms -- the bottom line. He said that employers need to be told they have the ability to shape their future workforce. With a shrinking workforce and "baby boomers" retiring, CEOs must look at how to recruit a healthy workforce.

Mr. Clymer further suggested that employers should be interested in school health because students' health affects learning, learning influences school system quality, and school system quality can be a factor in corporate location decisions. Mr. Clymer reviewed another reason businesses should become involved in student health issues; examining the indirect and direct cost of poor student health. He suggested that poor student health increases employee absenteeism, causes losses in productivity (due to parent worry, scheduling doctor appointments, etc.), and creates rising costs of sponsoring health insurance coverage for families.

Mr. Clymer reviewed the Office of Disease Prevention and Health Promotion's (ODPHP) ten leading health indicators, including:

- physical activity,
- overweight and obesity,
- tobacco use,
- substance abuse,
- responsible sexual behavior,
- mental health,
- injury and violence,
- environmental quality,
- immunization, and
- access to health care.

According to Mr. Clymer, employers should be interested that 43 % of high school graduates are smokers, 77 % do not eat five fruits and vegetables a day, 39 % do not

engage in physical activity, 25 % are already overweight and obese, and that all of these %ages are increasing.

Private sector businesses are already involved in schools but we (health and education professionals) need to help get them involved in school health. Avenues Mr. Clymer suggested include:

- sponsoring school events (especially sporting events),
- supplying and encouraging school volunteer and youth mentor programs,
- offering school mentoring programs,
- serving on school boards, and
- influencing government officials.

Mr. Clymer reminded the participants that schools are also employers and that they have to compete for qualified workers. Schools have the opportunity to influence the labor market through the coverage of clinical preventive services and comprehensive worksite health promotion programs.

Mr. Clymer offered suggestions to support business and school collaborations, including:

- Creating environments in schools, worksites, and communities that encourage and support healthy lifestyles. (Examples of health ventures that businesses and schools can take together include: offering continuing or adult education classes, providing accessible recreational facilities (pools, tracks, etc), developing health promotion programs for schools and worksites, negotiating for health plans, and supporting school programs that give students the knowledge and skills to become healthy and productive adults.)
- Schools should become model employers.
- Quantify problems and opportunities relating to student health from a business perspective.
- Start small because initial success can lead to larger ventures.

Presenter: Dr. Brenda Welburn
Executive Director
National Association of State Boards of Education (NASBE)

Dr. Welburn spoke from the perspective of general education as she discussed NCLB. She emphasized the need for people in education and people in school-based health to work together, embrace their common ground, and find a language that fosters effective communication between the two groups.

Dr. Welburn said that education has been noticed by the Federal government with this act, but that it "needs some ironing." She said that most people do not know that state Boards of Education set standards for schools and that NCLB will bring about major changes to most school systems. Dr. Welburn submitted that NCLB will challenge

school districts because the Federal government is changing requirements for states. States must keep in mind that money can be shifted out of school health programs. She added, however, that schools designated as low performing schools can be given Title I funds for supplemental service, making it nearly impossible to "leave a child behind" without paying attention to health.

Dr. Welburn stated that she believes partnering with organizations is logical and can be effective. An example of a partnership that could be highly effective is child immunization. In fact, in the future, Dr. Welburn sees that school immunization programs will provide for immunizations if parents cannot. For example, before the start of the 2001-02 school year, in Washington, DC, school administrators required all students to have their immunizations up-to-date before they could attend classes. If their immunizations were not current, they were not allowed to attend school. As a result of this, hundreds of children were not able to start school on time. Dr. Welburn suggested that this situation should not have happened and wouldn't happen if we take advantage of partnering opportunities. Partnerships with organizations for school health-related issues have to be multifaceted, and they must include partnerships with parents who also must understand health needs of their children.

Dr. Welburn cautioned, however, that partnerships do not always work. Often time is necessary to foster these partnerships to the appropriate depth. Political and philosophical differences can strain private organization partnerships with public schools. School-based sex education is one example of a program that is often affected by political and philosophical differences of organizations and schools.

Dr. Welburn closed by talking about how education and health professionals can partner within school systems. The two disciplines need to talk to each other in the same way, using the same language. Education and health professionals must talk and listen to each other, recognize the desired outcomes, embrace the common ground, and find advocates for internal support and collaboration.

Questions for Mr. Clymer and Dr. Welburn:

Question to Dr. Welburn: Do Title I funds for special programs include programs like Sylvan Learning Centers, after school programs, or faith-based programs?

Answer: The state has to give the guidelines, but it is possible that those types of programs could be included.

Question to Mr. Clymer: You say that behaviors are, in part, responsible for a great deal of the health-related problems today and that if these behaviors can be modified, we will see a decrease in the incidence of negative health outcomes. What do you recommend we do with children who come from distressed communities where the needs and pressures are so different?

Answer: Students can still bring health-related information home to their parents, but the schools have to send the information home. Also, school professionals are best at educating; therefore, they can contribute by educating employers and parents with the hopes of creating a healthier workforce. In this way, parents hear consistent messages from the information kids are bringing home from school and from their employers, and they can be a more powerful force in health education.

Question to Mr. Clymer: There are a great number of business partnerships with school systems that are unhealthy. An example of this is the proliferation of soda vending machines in so many public schools. What do we do about this?

Answer: Part of the problem with our tendency toward over consumption of sodas and over consumption of foods in general is that we are faced with advertisements for "super-sized everything." These messages are constantly in front of our kids. We can remind these companies that the "business of business is business," and that schools understand the marketing mentality. However, we invite business to look at business from a different perspective. Businesses should be asked to capitalize on the opportunity to work together with schools to create a healthier workforce for tomorrow. They should also be shown what their bottom line will be if they do not have the healthy workforce they need in the future.

Dr. Welburn added a response: Vending machines and other business partnerships (sponsorships, vendor relationships for school stores, etc.) in schools supplement the school income. If schools were sufficiently funded, this conversation may never need to occur.

Question to Dr. Welburn: There were two good reasons given for why partnerships between health and education can fail to work. A third may be that too often the burden is placed only on local communities to form partnerships, and they often have limited short-term funding. Schools are burdened with hosting small partnerships that are temporary.

Answer: A partnership that is larger and broader may meet with less resistance from schools, particularly if it is more likely to be permanent. The American Cancer Society is a good example. Schools are more likely to engage with them because they are nationwide and statewide and have been partnering for years.

Section Title: The State of School Health in the United States

Presentation: Results of the 2000 School Health Policies and Programs Study (SHPPS 2000)
Presenter: Dr. Laura Kann
Chief
Surveillance, Evaluation and Research Branch
Division of Adolescent and School Health
Centers for Disease Control and Prevention

Dr. Kann provided an overview of the findings of the landmark School Health Policies and Programs Study 2000 (SHPPS 2000), the most comprehensive assessment of school health programs ever undertaken. Dr. Kann framed her presentation by talking about the population of kids in schools in the United States and the health risk behaviors some practice.

There are approximately 54 million children attending the 117,000 schools in the U.S. About one-third identify themselves in minority groups. School systems are diverse; in 22 of the 25 largest urban school districts, "minorities" are the majority. In the San Diego schools at least 65 languages are spoken, and students there come from more than 100 countries. In the New York City schools, students speak more than 140 languages. This means that schools must struggle with many issues, including how to communicate with students and families, what to serve in the cafeteria that will be acceptable to the many cultures and customs that their students represent, etc. Approximately 17 % of children and youth live in families with incomes below the poverty level (an annual income of $16,600 for a family of four).

After providing general statistics regarding components of the Nation's school system, Dr. Kann reviewed adolescent risk behavior. She divided these behaviors into three groups: those that contribute to chronic disease later in life, those that contribute to unintended pregnancy and STD rates, and those that contribute to the leading cause of death (injury and violence) during childhood and adolescence.

Regarding behaviors that contribute to chronic disease later in life, she stated that in an average class of 30 high school students: three are overweight, 10 are cigarette smokers, 11 do not participate in rigorous physical activity, and 23 do not eat five fruits or vegetables a day.

With regard to unintended pregnancy and STD rates, Dr. Kann stated that in an average class of 30 high school students, 15 have had sexual intercourse, five have had four or more sexual partners, and 11 have had sex within the past three months. Among the 11, five did not use a condom and nine did not use any type of birth control.

With regard to injury and violence, research indicates that in an average class of 30 high school students, 11 children have been in a physical fight in the past year, five have

carried a weapon in the past month, and three have attempted suicide during the last year. Ten have ridden with a driver who had been drinking alcohol, and five rarely or never wore safety belts. Regarding factors that contribute to injury and violence, 15 have consumed alcohol in the past month, and eight have used marijuana.

For each category, Dr. Kann detailed the health outcomes and trends associated with the behaviors listed above. Also, for each issue, she reviewed state, district, and school-level requirements. Dr. Kann explained that the SHPPS 2000 study also examined content of instruction specific to physical activity, nutrition, sex education, safety, substance use and abuse, and mental health education in the Nation's schools.

In her review of the study's findings, Dr. Kann suggested actions that states, districts and schools can take and/or services schools can provide, including:

- Encouraging more physical activity (individual, team-based, and regular daily activity options such as recess),
- Employing qualified staff to teach health education,
- Promoting fat-reducing food preparation practices in school cafeterias,
- Offering healthier meal options,
- Enhancing Food Service Manager qualifications,
- Limiting access to sodas and unhealthy snack foods,
- Prohibiting tobacco use on school grounds,
- Increasing the availability of school nurses,
- Increasing mental health and social services staff in schools,
- Encouraging case managers to keep written plans and records, and
- Requiring student assistance programs in schools.

In closing, Dr. Kann said, "School health programs are definitely alive in our Nation's schools. Many good things are happening. But not all schools and all programs match our vision for what we should be doing for kids. The real worth of this study will be determined by how much it helps improve policies and programs for kids. Hopefully you will find some of these data useful for program planning and decision making."

A summary report of SHPPS 2000 can be found at http://www.cdc.gov/shpps. *The Journal of School Health* Vol.17 (7), September 2001 is also dedicated to SHPPS.

Section Title: Realizing the Vision for Improving Health and Education Outcomes of America's Children and Youth: State and District Success Stories

Presentation: The Michigan Model
Presenter: Donald Sweeney
School Health Unit
Michigan Department of Community Health

Mr. Sweeney gave a brief overview of the Michigan Model for Comprehensive School Health Education. He said it is the fastest growing school health education program in the nation. The Michigan Model is being implemented in over 90 % of Michigan's public schools and in more than 200 private and charter schools. Comprehensive school health education now reaches 42 states, foreign countries, universities, and medical schools through the Michigan Model.

The Michigan Model was established in 1985 as a cooperative effort of seven state agencies, including Public Health, Education, Mental Health, Social Services, Highway Safety Planning, State Police, and Substance Abuse. These agencies agreed to collaborate in providing an efficient delivery mechanism for key disease prevention and health promotion messages.

Mr. Sweeney explained that representatives from the state agencies collaborated so that they could provide a common direction and common themes. After years of trying the "band-aid" approach, (using programs such as DARE, MADD, and others), the agencies realized they were doing their school systems a great disservice.

A network of 115 professional and volunteer groups worked with the program to create age-appropriate curricula for students. The Michigan Model curriculum facilitates interdisciplinary learning through lessons that integrate health education into other curricula, including language arts, social studies, science, math and art. Teacher training in implementation of the Model ensures that students and their schools get maximum benefits.

The Michigan Model is divided into 9 levels, including individual grade level programs from kindergarten through sixth grade, and combined grade programs for seventh through ninth grades and tenth through twelfth grades.

An example of modules for grades 7-8 includes:

- Nutrition: What's Food Got to Do With It?
- Violence Prevention: The Two R's for Stopping Assault and Preventing Violence
- HIV, AIDS, and Other STDs Prevention: HIV, AIDS, and Other STDs
- Substance Abuse Prevention: Protect a Friend, Share Your Skills
- Physical Activity: It's Time to Move
- Tobacco Prevention: It's No Mystery: Tobacco Is a Killer

Michigan invited collaborations with organizations such as:

- General Motors (provided seatbelts for safety lessons),
- Meijer Corporation Inc. (developed and distributed a video on recycling for parents), and
- Blue Cross and Blue Shield (provided pedometers to a walking club).

Mr. Sweeney shared that some schools have incorporated a "Walk to California" club, in which they use pedometers to gauge the distance walked. Teachers integrated math, science, and geography lessons into the walking adventures.

Other organizations that contribute to the Michigan Model include:

- Comerica Bank (provided funding for the development and distribution of parent materials),
- United Dairy Industries of Michigan (provided annual nutrition training and materials),
- Michigan Railroad Commission (develops safety resources and activities),
- Michigan Parent-Teacher Association (assists in developing and distributing parent materials),
- Kellogg Company (provides videos for nutrition lessons),
- Proctor and Gamble (contributes toothbrushes for primary grades),
- K-mart Corporation (provides coupons for free batteries for smoke detectors),
- American Cancer Society (provides materials, training and classroom support),
- Michigan Lung Association (provides materials, training and classroom support), and
- American Heart Association of Michigan (provides materials, training and classroom support).

The agencies and organizations involved in the Michigan Model are working well together. Mr. Sweeney offered that communication among the collaborating organizations and agencies is very important. He stressed that to achieve this level of collaboration, the agencies involved must understand a common language and buy into a common goal. Education professionals must be taught that health professionals are looking for healthy behaviors. Likewise, health professionals must be taught that education professionals are looking for achievement outcomes. The key to success is communicating and understanding each other's position.

The next steps for the Michigan Model include refocusing efforts toward creating a surveillance tool. Currently, Michigan uses national and local surveys that are available (Youth Risk Behavior Surveillance System (YRBSS) and the Youth Tobacco Survey (YTS)). However, the state plans to create one survey specific for Michigan's needs, the Michigan Adolescent Risk Survey (MARS).

Presentation: Data Maps and Linkages to Learning
Presenter: Russell Henke
Coordinator of Health Education
Montgomery County (Maryland) Public Schools

Mr. Henke reviewed the last 30 years in education history as an environmental scan. During the 70's there were rapid changes in education: Enrollments went down, schools closed, there was a great loss of teachers, and significant budget cuts. Those who were teaching were teaching straight factual information. In the 80's, enrollments continued to decline, however researchers began to examine what was happening. During the 90's, enrollments began to climb again, schools started to reopen, achievement tests were implemented, failures and dropouts were considered unacceptable, and Individualized Education Plans (IEPs) were set in place.

Mr. Henke focused on Montgomery County, MD, immediately north of Washington, DC. Montgomery County has the largest per capita income in the state. There are 138,000 students in the school system, and population growth estimates indicate there will be 142,000 in 2006. A total of 184 schools are in the county, and 127 languages are spoken. These demographics indicate that Montgomery County is very diverse and has a wide range of needs.

Through research, education experts in Montgomery County found that 95 % of children who have dropped out of school have health-related problems. They decided to take a close look into communities in the county to learn more about the lives of the county's children. The researchers compared health and quality of life findings to achievement outcomes.

Their research suggested that children from Silver Spring, Rockville, and Germantown receive more free or reduced meals at school, change schools more often, are more likely to use addiction services, have a higher incidence of teen pregnancy, and are more likely to be uninsured. To determine achievement outcomes, they used the Maryland School Performance Assessment Program (MSPAP), which revealed that children who received the lowest scores also came from Silver Spring, Rockville, and Germantown.

Data maps were created to graphically depict the convergence of this information. These data maps were presented to educators, administrators, funders, and other public officials to show the relationship between the health needs of children and their educational outcomes. The maps showed the need for increased student services, particularly elementary and junior high school counselors and nutrition and food service experts. In both cases, and as a result of the data map presentation, significant strides were made in these areas.

Mr. Henke introduced *Linkages to Learning*, which is the Montgomery County Department of Education's collaborative school health effort with Montgomery County's Health and Human Services Department. The program seeks to improve the well-being

of children and their families through collaborative delivery of school-based services that address social, economic, health, and emotional issues that can interfere with the academic success of a child.

The services *Linkages to Learning* provides include supporting students' adjustment to school; counseling individuals, families, and groups; providing preventive health care and health education; providing workshops and classes on issues of parenting, nutrition, and acculturation; assisting with food, utility, and housing problems; providing translation services for non-English speaking families; assisting parents in completing financial and medical assistance forms; planning community outreach and prevention programs; and empowering parents to access the system on their own. The program was started in 19 elementary and middle schools in the county, and depending on the success of the program, it will be extended to county high schools in the future.

Mr. Henke highlighted other Maryland State and Montgomery County programs. He said that Maryland requires that public schools offer health education in grades K – 8 and again in 10th grade as a graduation requirement. The eight topic areas that are covered in the curriculum were built around the priority areas established by the Centers for Disease Control and Prevention (CDC). In Montgomery County, educators have shaped their curriculum to make the materials as age-appropriate as possible and to encourage teachers to spend more time on teaching skills rather than factual information. Skills that are taught include communication, decision-making, stress and anger management, and goal setting among others.

Montgomery County health and education officials have made significant progress in health education, but they also recognize the need to nurture the health of their communities to promote higher health and education outcomes.

Questions for Don Sweeney and Russell Henke:

Question to Mr. Sweeney: How long did it take to put the Michigan Model program together?

Answer: It took about 3 meetings with strong support from the Governor of Michigan.

Question to Russell Henke: Are you concerned about what might happen if we show these charts, implement these programs, and (health and education) improvements are not reflected in future charts and data maps?

Answer: It is a concern, but we must try. And we must not lose the opportunity to try.

Question to Mr. Henke: The same schools (Silver Spring, Rockville, and Germantown) have been developing innovative ways to teach and reduce class size. Can we say that these efforts alone are going to matter?

Answer: We need more time for evaluation. We haven't had enough time to see what is really going on in the county. It is hard to say with certainty.

Question to Mr. Henke: Would you say that we need a paradigm shift with health education influencing curriculum?

Answer: We are at the point where we are going to see a shift in health education. Public educators will be responding to health educators because there is not one single health issue that does not affect education.

Day Two
May 23, 2002

Section Title: Sharing Responsibility for Health and Education Outcomes for Children and Youth: Commentary and Discussion from Federal Agency Representatives

Presenter: Dr. Eve Slater
Assistant Secretary for Health and Human Services
U.S. Department of Health and Human Services

Dr. Slater shared her reflections on the Nation's health and the efforts in place to reduce negative health outcomes and eliminate disparities in health and health care. Dr. Slater stated that only about one-third of the concerns that top the Nation's health agenda are linked to genetics. About 50% of health outcomes are preventable, and we do have the ability to significantly improve quality of life. The time to intervene and set standards for healthier outcomes is before we get too old. She suggested that early behavior interventions are critical, but to be effective they must not be viewed as punitive. This is why the efforts of NCCSH are important.

According to the latest studies, Dr. Slater reported nearly 3,000 children begin smoking each year. Even though prevention efforts have yielded a 25% reduction in cigarette smoking across the board, and prevention programs led the reduction in second hand smoke, adolescents ages 15-17 still have an initiation rate of cigarette smoking that is 32-33% above the national average. Somehow prevention messages are not resonating with adolescent populations to the degree necessary.

Today's children are not as physically active as they have been in the past, with only 29% of teens participating in daily physical activity. Statistics suggest that children are watching television at higher rates than ever before. Dr. Slater sympathized with parents by saying it's hard to know how to wean children off of television. Furthermore, approximately 75% of children do not eat five fruits and vegetables a day. The high percentage of overweight adolescents (13 to 14% of the entire adolescent population), a number that has tripled since 1980, can be attributed to the consequences of these behaviors. Currently, 61% of adults are overweight, and this number promises to rise, as today's adolescents become tomorrow's adults.

Sexual behavior statistics among adolescents are alarmingly high as well. There were nearly 800,000 teen pregnancies and three million cases of sexually transmitted disease reported last year. Alcohol, tobacco, and other drug use rates are also disturbing. For example, 4.4% of 10^{th} graders and 5.6% of 12^{th} graders have tried Ecstasy. Two-thirds of the deaths of children and youth ages 5 to 19 are due to motor vehicle accidents. Research suggests that nearly 10% of suicides among this age group are preventable if parents or loved ones know how to recognize the warning signs.

Dr. Slater gave a brief overview of Healthy People 2010 (HP 2010). HP 2010 is the set of major health objectives for the Nation for the first decade of the new century. States, communities, professional organizations, and others are encouraged to use the objectives to help them develop programs to improve important health outcomes.

HP 2010 includes 467 key parameters and a list of categories. HP 2010 also includes 10 leading health indicators, and each indicator has one or more objectives from HP 2010 associated with it. As a group, the health indicators reflect the major health concerns in the United States at the beginning of the 21st century.

These leading health indicators are:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

More information about Healthy People 2010 is available at www.health.gov/healthypeople.

Another important health initiative is the President's Task Force on the Environment and Health. DHHS Secretary Tommy Thompson and EPA Administrator Christine Whitman have joined forces to address issues related specifically to the environment and health. The Task Force plans to gain more information about environmental impact on health as it relates to asthma, developmental disorders, cancer, and injuries.

Presenter: Dr. Susan Neuman
Assistant Secretary for Elementary and Secondary Education
U.S. Department of Education

Dr. Neuman focused on the importance of treating the whole child. She stated that our education system and educators teach the whole child in the earlier years, but we lose sight of this approach as children get older. We tend to pay less attention to older children's overall health and well-being and their emotional, social, and cognitive development.

Dr. Neuman stated that we can tell when kids are not learning. We've found that when kids aren't learning, typically they are not healthy, either. Health plays a significant part in the social and emotional development of children. She also suggested that learning difficulties could be viewed as health impairments. It is likely that children with learning disabilities are not developing cognitively, socially, and/or emotionally.

Dr. Neuman said NCLB is landmark legislation that can reform today's schools. She restated the four pillars of the act: stronger accountability for results, greater flexibility for states and communities, concentration of resources on proven education methods, and more choices for parents. She stated that these pillars require greater collaboration between educators and health educators. She also stressed that one of the key elements of the act is choice for parents, inviting them to pay greater attention to their child's (or children's) education.

Dr. Neuman briefly talked about the Presidential initiative, *Good Start Grow Smart,* an initiative targeting children in early childhood under the age of five. Early childhood is a critical time for children to develop the physical, emotional, social, and cognitive skills they will need for the rest of their lives. The initiative addresses three major areas: strengthening Head Start programs; partnering with states to improve early childhood education; and providing information to teachers, caregivers, and parents. All early childhood and Head Start training will start during the summer of 2002.

Dr. Neuman reiterated that research shows unhealthy students don't learn, and that there is a reciprocal relationship between health and learning. She said it is important for health professionals to get their message out and make a case for the health education agenda.

Presenter: Roberto Salazar
Administrator
Food and Nutrition Service
U. S. Department of Agriculture

Mr. Salazar stressed the importance of proper nutrition for children. His consistent and recurring message, "Hunger is innate, eating right is learned behavior," was well received. Mr. Salazar said that schools must focus on nutrition and understand the complex relationship between the classroom and the cafeteria. He noted that the school lunch program has made a significant contribution to the health and nutrition of children in schools, and that the school breakfast program has the same potential. Research suggests that children who eat a school breakfast attend school, are not late to school, are better behaved, and are considered at less risk for negative outcomes.

Mr. Salazar also indicated his strong support for the integration of nutritional education into academics and the importance of carrying that education through to behaviors in cafeteria selections. He recognized that changing children's behavior with regard to food is a difficult challenge. Children are habituated to filling up on meals with little

nutritional value, and they often don't leave room for foods they should eat. He also mentioned that the time children have to eat lunch is important; most schools do not allow enough time for lunch.

The Food and Nutrition Service is working on a new initiative called *Eat Smart, Play Hard*, which is designed to foster positive changes in eating and physical activity behaviors in order to improve long-term health. The initiative will convey science-based, behavior-focused, and motivational messages about healthy eating and physical activity based on the Dietary Guidelines for Americans. It will use a mascot and other materials for delivering nutrition and physical activity messages to children and their caregivers. The initial campaign messages focus on four basic themes: breakfast, snacks, balance, and physical activity. The target audience is preschool and school-aged children and youth ages 2 to 18 years.

Another initiative from the Food and Nutrition Service is *Changing the Scene: Improving the School Nutrition Environment,* which is a collaborative effort of 16 nutrition-oriented organizations. This action kit can be used at state and local levels to educate decision makers about the role school environments play in helping students meet the Dietary Guidelines for Americans. It can also be used to help motivate them to take action that will contribute to sound nutrition and physical activity patterns for today's students.

Mr. Salazar noted that President Bush is committed to school health. During his administration there will be a great deal of focus on underutilized programs such as the Food Stamp program, school breakfast program, and the summer food program.

Presenter: William Woodruff
Deputy Administrator
Office of Juvenile Justice and Delinquency Prevention
U.S. Department of Justice

Mr. Woodruff said that truancy is also a significant education problem as well as a significant health issue. When children fail in school, their problems usually don't end there. If these children were to be followed home, people would find that these children have troubled personal lives as well.

Mr. Woodruff emphasized that educators must pay attention when kids start to fail. Even if beginning to fail is seen as only a small problem, educators must not "be too busy" to notice. If educators fail to address these issues when they are small, they are likely to become significantly bigger problems later.

He used the example of a young child missing one day of school a month. This child is missing out on learning, but might also be running away from pain toward pleasure. This child might suffer from being called names in school so s/he doesn't go to school. This child might seek out another environment in which s/he is accepted, and in this environment (outside of school) s/he is likely to be surrounded by other truants. From

within this environment a whole other lifestyle might be learned, and that lifestyle is not likely to be conducive to healthy social, emotional, and cognitive development. Mr. Woodruff reiterated that it is important to pay attention to when children and youth start to fail and when they start to miss school, even once a month.

School health is an issue of interest to the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the entire Department of Justice because children who have school or health problems early on often become people who are entangled in the justice system later in life.

Question for Mr. Woodruff: Does OJJDP have any interagency collaborations with regard to conducting studies or developing after school or other enrichment programs?

Mr. Woodruff: Yes, there are already studies underway. OJJDP is good at reaching out and working with other agencies. OJJDP is also open to working with other agencies to implement programs. Effective programs often need to be complex, because delinquency is a complex issue. Studies indicate that there are basically three stages of delinquency: prospective delinquency (children who are not currently in trouble but are at risk for trouble in the future), children in the justice system, and children coming out of the justice system. Each stage requires a different type of intervention, and having a broader range of specialists involved increases the number of issues the intervention can address, allowing for a more comprehensive intervention.

Section Title: Planning for Success: Setting the Agenda for NCCSH

On the first day of the meeting, participants were divided into small working groups. Each group was asked to address a set of prescribed questions regarding strategies for improvement in health and education outcomes. The questions and results are listed below.

Questions: What strategies would enhance efforts of Federal departments and agencies to improve health and education outcomes for children? What strategies might Federal departments and agencies employ to enhance collaboration?
(The answers are ranked by the number of times the strategy was suggested.)

1. Synthesize evidence on links between health and educational achievement (23 votes)
2. Work for recommitment to Joint Statement on School Health (17 votes)

3a. Integration and communication among Federal agencies (15 votes)
3b. Feds should require, recommend, and create funding opportunities for cross-collaboration (15 votes)

5. Get more Federal agencies to communicate efforts across disciplines – increase collaboration (use "Changing the Scene" model) (12 votes)
6. Revitalize the Interagency Committee on School Health (10 votes)
7. Strategic planning meeting for Federal representatives – include forum for educators, public health, parents, etc. to express local challenges – local, grassroots approach (3 votes)

8a. Get Feds to identify key outcome measures of educational achievement that all can use (2 votes)
8b. Have Federal agencies recognize NCCSH as an advisory group (2 votes)
10a. Get other people into the room (1 vote)
10b. Move 5-a-Day collaboration to the states (1 vote)

Questions: What specific actions can the NCCSH take as a collective to improve health and education outcomes for children? What outreach should NCCSH undertake to Federal agencies? What should be the relationship be between NCCSH and any or all Federal agencies? What priority would you give to these actions?
(For background, please refer to our Mission, Goals and Objectives statement and Operating Principles.)

1. **Promote school health research agenda with NIH – open-ended with focus on health and education outcomes (29 votes)**
    - Convene researchers to partner on joint studies – pool resources
    - Endorse each others' projects to enhance credibility and reach

2. **Develop white papers, research/information pieces (19 votes)**
    - Annually pick an implementation barrier to resolve at state and local level
    - Explore intersection between health and education
    - Explore quality improvement piece – include AHRQ
    - Create recommendations on information sharing
    - Explore concept of how to collaborate as it relates to school health; define collaboration
    - Work on the connection between health and education
    - Develop policy statements we can agree upon
    - Write policy statements to inform others
    - Develop fact book with three topics of interest for each
    - Adopt written objectives across disciplines

3. **Explore more direct marketing of our message (12 votes)**
    - To parents – promote public will
    - Develop joint marketing plans
    - Increase outreach
    - Reach out to textbook publishers to integrate health messages (Ed. note: I assume that means other curricular disciplines)

4. **Host critical issues meetings (10 votes)**
    - Hold working group meetings on business or policy
    - *Healthy People 2010* meeting
    - Hold one-day conference to educate legislators to raise awareness – adolescent health summit

5. **Develop stronger relationships between NCCSH and the Interagency Council on School Health (9 votes)**

6. **Get more Federal agencies involved (6 votes)**

7. **Increase advocacy work (5 votes)**
    - Support work of "Friends of School Health" coalition
    - Support TE^3 (Transportation Enhancement Act) Safe Routes to School
    - Advocate for students with disabilities – health and mental health needs
    - Work to get nurses and health educators into every school to educate families and children

8. **Provide resources to NCCSH members and others (4 votes)**
    - Disseminate research and data – connect different data sources
    - Add links to website to data sources
    - Distribute health and safety materials

9 (tie). Increase communications during the year (2 votes)
    - Establish NCCSH listserv; hold more meetings; periodic conference calls
    - Hold virtual meetings of NCCSH to respond to urgent issues

- Work on communication with member organizations through the year
- Hold multiple meetings each year – focused meetings – need more work in progress, increase dialogue
- Inform others about products, resources and materials

9 (tie). Work on membership; invite other groups to the table (2 votes)

- Reach out to accreditation and certification groups, schools of public health; involve these agencies in the NCCSH meeting
- Include legislators, others that don't fit into health or education
- Get policy makers to our meetings